

## TARGETED CASE MANAGEMENT FOR PREGNANT WOMEN AND INFANTS FAMILY NEEDS ASSESSMENT

### **DEMOGRAPHICS:**

Date: \_\_\_\_\_ Name: (Last, First) \_\_\_\_\_

DOB: \_\_\_\_\_ Estimated Date of Delivery (for Prenatal Clients): \_\_\_\_\_ SSN: \_\_\_\_\_

Parent(s)/Guardian(s): \_\_\_\_\_

Alternate Contact name, address, and phone:

\_\_\_\_\_

Site of assessment: ☒ Home ☒ Clinic ☒ Other, specify: \_\_\_\_\_

If not in home, explain why: \_\_\_\_\_

Client/Family Members present at assessment: \_\_\_\_\_

| HOUSEHOLD MEMBERS | RELATION | AGE | HOUSEHOLD MEMBERS | RELATION | AGE |
|-------------------|----------|-----|-------------------|----------|-----|
|                   |          |     |                   |          |     |
|                   |          |     |                   |          |     |
|                   |          |     |                   |          |     |
|                   |          |     |                   |          |     |
|                   |          |     |                   |          |     |

Health insurance/Medicaid Number: \_\_\_\_\_

**☒ Referrals for health insurance needed; see service plan.**

### **MEDICAL:**

Family's understanding/acceptance of client's needs: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Obstetrician: \_\_\_\_\_ Pediatrician: \_\_\_\_\_

Location: \_\_\_\_\_ Location: \_\_\_\_\_ Location: \_\_\_\_\_

Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_

**☒ No PCP identified; see service plan**

Current status of preventive health care and immunizations (client and family): \_\_\_\_\_

Home remedies/traditional health practices: \_\_\_\_\_

**☒ Referrals needed for preventive health care and immunizations; see service plan.**

Current status of dental care (client and family): \_\_\_\_\_

**☒ Referrals needed for dental care; see service plan.**

Current medical/physical status of family members: \_\_\_\_\_

**9 Referrals needed for medical care; see service plan.**

**DEVELOPMENTAL/ EDUCATIONAL/ NUTRITIONAL:**

Developmental status/concerns \_\_\_\_\_

ECI/ISD provider: \_\_\_\_\_

**9 ECI/ISD referral needed; see service plan.**

Educational/vocational status/concerns:

**9** In regular classes      **9** In special education or resource classes

**9** Transitional services: \_\_\_\_\_

**9** Vocational: \_\_\_\_\_

**9** Other concerns: \_\_\_\_\_

**9 Referrals needed; see service plan.**

Current nutritional status: \_\_\_\_\_

Family traditions: \_\_\_\_\_

**9** On WIC      **9** On Food Stamps      **9** Other Food Assistance: \_\_\_\_\_

**9 Referrals needed; see service plan.**

**SOCIOECONOMIC:**

Employment: \_\_\_\_\_

Income:

| FAMILY MEMBER: | SOURCE: | AMOUNT/FREQUENCY: |
|----------------|---------|-------------------|
|                |         |                   |
|                |         |                   |
|                |         |                   |

TOTAL PER MONTH: \_\_\_\_\_ NUMBER OF PEOPLE SUPPORTED: \_\_\_\_\_

Financial stresses: \_\_\_\_\_

Child of Migrant Worker? **9** Yes **9** No      If yes, does the client also migrate? **9** Yes **9** No

**9 Referrals needed for financial services; see service plan.**

**HOUSING:** **9** Apartment      **9** House      **9** Mobile Home      **9** Homeless      **9** Other: \_\_\_\_\_

Number of bedrooms: \_\_\_\_\_ **9** Own      **9** Rent      **9** Share housing with: \_\_\_\_\_

**9** Family moves frequently/anticipates moving \_\_\_\_\_

Other concerns regarding housing: \_\_\_\_\_

Other safety concerns: \_\_\_\_\_

**9 Referrals needed for housing; see service plan.**

**MEDICAL TRANSPORTATION:**

**9** Uses Medicaid Transportation services.

If yes: **9** Reimbursed for private vehicle **9** Reimbursed for public transportation

**9** Uses public transportation, specify: \_\_\_\_\_

**9** Has own transportation, specify: \_\_\_\_\_

**9** Other, specify: \_\_\_\_\_

Emergency transportation: \_\_\_\_\_

Safety(car seats): \_\_\_\_\_

**9 Referrals needed for transportation; see service plan.**

**LEGAL ISSUES:**

**9** Marital or child support

**9** Guardianship

**9** Immigration

**9** Criminal

**9** Truancy

**9** Eviction

**9** Lawsuit pending

**9** Restraining Order

**9** Other: \_\_\_\_\_

Comments: \_\_\_\_\_

**9 Referrals needed for legal assistance; see service plan.**

| PSYCHOSOCIAL ISSUES |                           |  |
|---------------------|---------------------------|--|
|                     | Marital                   |  |
|                     | Parenting                 |  |
|                     | Siblings                  |  |
|                     | Other Family              |  |
|                     | Community Support Systems |  |
|                     | Child Care                |  |
|                     | Respite Care              |  |
|                     | Family Violence           |  |
|                     | Substance Abuse           |  |
|                     | Mental Health             |  |

|                            |                    |  |
|----------------------------|--------------------|--|
| <b>PSYCHOSOCIAL ISSUES</b> |                    |  |
|                            | Religious/Cultural |  |

**9 Referrals needed; see service plan.**

**OTHER COMMUNITY AGENCIES INVOLVED:**

| AGENCY: | LOCATION: | CONTACT/TELEPHONE: |
|---------|-----------|--------------------|
|         |           |                    |
|         |           |                    |
|         |           |                    |
|         |           |                    |
|         |           |                    |

**EMOTIONAL/PSYCHOLOGICAL ISSUES:**

**CLIENT/FAMILY'S GOALS AND PRIORITIES:**

**CASE MANAGER'S ADDITIONAL COMMENTS:**

SIGNATURE/TITLE: \_\_\_\_\_ DATE: \_\_\_\_\_